TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FRISCO MEDICAL CENTER

Respondent Name
AMERISURE PARTNERS INSURANCE COMPANY

MFDR Tracking Number
M4-16-1961-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "they have not paid what we determine is the correct allowable per the APC allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account. Per the new fee schedule this account qualifies for an Outlier payment"

Amount in Dispute: $1,923.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Worker's Compensation follows Medicare OPPS, which uses a line level formula in determining outlier-qualified payments. There were no line level qualifications."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2015	Outpatient Hospital Services	$1,923.59	$1,794.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure code 96375 has status indicator S denoting a significant procedure not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $18.60. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $31.63 multiplied by 9 units is $284.67. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $284.67. This amount multiplied by 200% yields a MAR of $569.34.

   - Procedure code 96361 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $18.60. The non-labor related portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor related amounts is $31.63 multiplied by 2 units is $63.26. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $63.26. This amount multiplied by 200% yields a MAR of $126.52.

   - Per Medicare policy, procedure code 96374 may not be reported with procedure codes 74177 and 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedures. Separate payment is not recommended.

   - Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

   - Procedure code 80053 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 83690 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 82150 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85610 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85730 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 71010 has status indicator Q3 denoting conditionally packaged codes paid through a composite APC if OPPS criteria are met; however, the criteria for composite payment have not been met. Therefore, this line is paid separately and assigned status indicator S denoting a significant procedure not subject to multiple-procedure discounting. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $59.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $35.62. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $33.88. The non-labor related portion is 40% of the APC rate or $23.75. The sum of the labor and non-labor related amounts is $57.63. The cost does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $57.63. This amount multiplied by 200% yields a MAR of $115.26.
- Procedure code 73110 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date; however, as there were other STVX status services billed, this code is not separately payable.
- Procedure code 73060 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date; however, as there were other STVX status services billed, this code is not separately payable.
- Procedure code 73130 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date; however, as there were other STVX status services billed, this code is not separately payable.
- Procedure code 73590 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date; however, as there were other STVX status services billed, this code is not separately payable.
- Procedure code 73080 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date; however, as there were other STVX status services billed, this code is not separately payable.
- Procedure code 99284 has status indicator Q3 denoting conditionally packaged codes that may be paid through a composite APC; however, the criteria for composite payment have not been met. Therefore, this line is paid separately and is assigned status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $333.80. This amount multiplied by 60% yields an unadjusted labor-related amount of $200.28. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $190.51. The non-labor related portion is 40% of the APC rate or $133.52. The sum of the labor and non-labor related amounts is $324.03. The

cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $324.03. This amount multiplied by 200% yields a MAR of $648.06.

- Per Medicare policy, procedure code 96372 may not be reported with procedure code 96374 billed on the same claim. Payment for this service is included in the payment for the primary procedure.
- Procedure code Q9967 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 74177, 72125, 70450, and 70486 have status indicator Q3 denoting conditionally packaged codes paid under a composite APC. Services assigned to composite APCs are major components of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a "without contrast" CT procedure is performed on the same date of service as a "with contrast" CT, APC 8006 is assigned rather than APC 8005. These services are assigned to composite APC 8006 for computed tomography (CT) services including contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the claim. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which, per OPPS Addendum A, has a payment rate of $528.56. This amount multiplied by 60% yields an unadjusted labor-related amount of $317.14. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $301.66. The non-labor related portion is 40% of the APC rate or $211.42. The sum of the labor and non-labor related amounts is $513.08. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,775, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.307. This ratio multiplied by the billed charge of $9,569.13 yields a cost of $2,937.72. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $513.08 divided by the sum of all APC payments is 41.29%. The sum of all packaged costs is $919.83. The allocated portion of packaged costs is $379.78. This amount added to the service cost yields a total cost of $3,317.50. The cost of these services exceeds the annual fixed-dollar threshold of $2,775. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,419.61. 50% of this amount is $1,209.81. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $1,722.89. This amount multiplied by 200% yields a MAR of $3,445.77.

3. The total allowable reimbursement for the services in dispute is $4,904.95. This amount less the amount previously paid by the insurance carrier of $3,110.69 leaves an amount due to the requestor of $1,794.26. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,794.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,794.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.